



**The Department of Services
for Children, Youth and
Their Families**

Division of
Family Services

• Office of the Director •

(302) 633 - 2650

MEMORANDUM

To: Cari DeSantis

From: Carlyse Giddins 

SUBJECT: DFS-DPH MOU

Date: November 26, 2002

Attached please find a copy of the updated MOU between DFS and DPH. The MOU was updated through a committee chaired by Sue Radecki in partnership with representatives from public health. It has been circulated for suggestions and comments within the administrative management sections of both DFS and DPH, and is now ready for final review, approval and signatures by the appropriate leadership authorities to be incorporated and implemented as the revised MOU. Below are highlights of changes made to the revised MOU.

1. Defines high-risk infant referrals. Adds a High-Risk Infant Referral Protocol
2. Defines DFS referrals re substance abuse. Adds DFS Policy on Substance Abuse
3. Updates changes in referral process
4. Updates organizational chart
5. Describes the DFS Safety Planning process
6. Updates agency liaisons
7. Updates child death review process


MEMORANDUM OF UNDERSTANDING

Between

**THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND
THEIR FAMILIES
The Division of Family Services**

and

**DELAWARE HEALTH AND SOCIAL SERVICES
The Division of Public Health**

 12-16-02
Cari DeSantis
Secretary
Department of Services for Children
Youth & Their Families

Date

Vincent P. Meconi
Secretary
Department of Health and Social
Services

Date

 12/17/02
Carlyse A. Giddins
Director
Division of Family Services

Date

Maureen Dempsey, MD
Director
Division of Public Health

Date

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MEMORANDUM OF UNDERSTANDING
BETWEEN
DIVISION OF PUBLIC HEALTH
AND
DIVISION OF FAMILY SERVICES

I. INTRODUCTION

A. PURPOSE

This Memorandum of Understanding between the Division of Public Health (DPH) and the Division of Family Services (DFS) has been jointly developed for the agencies:

1. To work as a team on shared client cases to attain the most positive outcome
2. To provide each client with the most comprehensive care
3. To prevent duplication of activities

Further, the Memorandum will enable the agencies to:

- a. define the roles of staff in each agency
- b. clarify the expectations of each agency
- c. provide guidelines for case referral and case management
- d. establish joint training schedules
- e. provide orientation for one another on a regular schedule
- f. organize mechanisms for information sharing and problem resolution
- g. provide liaison or contact persons for each agency at county and state levels

B. AUTHORITY AND PHILOSOPHY

1. Division of Public Health

The authority of the Division of Public Health is set forth in Article XII of the Constitution of the State of Delaware which defines Division of Public Health responsibilities as maintaining the life and health of the people and supervising all matters related to public health. Specific responsibilities are given to Division of Public Health in Delaware Code, Title 16, Chapters 1 and 3; Title 29, Chapter 79; and Title 31, Chapter 28.

The philosophy of the Division of Public Health states:

- That optimum health is the maximum physical, mental, social and emotional state of well-being attainable by individuals, families and communities
- That all Delawareans have the right to the pursuit of optimum health, the freedom to make decisions affecting their health, and the responsibility to share in the attainment of optimum health

- That biological, emotional and social barriers which interfere with the pursuit of optimal health should be reduced or eliminated
- That the prevention, rather than treatment of disease and harmful environmental conditions is superior, both fiscally and morally, in the pursuit of optimal health. When prevention is not possible, treatment of disease/disability and/or correction of environmental conditions should be available to bring about optimum health.

2. Division of Family Services

Title 16, Chapter 9 and Title 29, Chapter 90 of the Delaware Code provides specific authority and responsibility for the protection of children to DFS. Generally, it is the courts which have the power to enforce and oversee the exercise of the agency's authority.

The DFS philosophy includes, but is not limited to, the following tenets:

- The safety of the child is the first priority of DFS
- Minimally adequate care standards are used in assessing a child's safety
- DFS intervention shall be as least intrusive as possible
- DFS believes most children are best cared for in their family setting and will offer services to assist in strengthening the family unit
- When placement away from the nuclear family is necessary, efforts are made to place children with relatives (least restrictive environment)
- DFS has the legal and professional obligation to protect the client's right to confidentiality of information

II. ROLES AND RESPONSIBILITY

A. DIVISION OF PUBLIC HEALTH

The mission of DPH is to protect and enhance the health of the people of Delaware. The Division accomplishes its mission by:

- Working together with others
- Addressing issues that affect the health of Delawareans
- Keeping track of the State's health
- Promoting positive lifestyles
- Responding to critical health issues and disasters
- Promoting the availability of health services

Scope of Services

The Division of Public Health is part of the health services delivery system as well as a partner in building health systems in the community to improve health status and health care access. The Division of Public Health offers a broad range of services by qualified professionals in many disciplines. These services are carried out in a variety of clinical sites throughout the state, in client homes, and in the community. (Appendix A).

DPH services include:

- Helping individuals and families find and use a medical home, regardless of insurance status
- Providing for the health promotion needs of children, such as immunizations, screening and assessments for the early detection of disease or disability, health teaching, and referring to a private physician for follow up and ongoing care
- Linking families to services, coordination of those services, parenting education and health teaching as part of the enhanced services provided to vulnerable populations, such as children at risk for developmental delay (Child Development Watch and Kids Care), pregnant women and teens (Smart Start), and families with complex needs
- Helping families to fully utilize the health system available to them
- Preventing, treating and controlling communicable diseases, including sexually transmitted diseases
- Family planning and fostering community strategies to prevent teen pregnancy

B. DIVISION OF FAMILY SERVICES

The mission of the Division is to promote the well-being and safety of children and their families through prevention, protection and permanency.

Title 16, Chapter 9 of the Delaware Code gives specific authority and responsibility to the Division of Family Services to receive reports of known or suspected child abuse, neglect or dependency; to investigate accepted reports; and to provide remedial services to children and families. While the law permits DFS to request that other agencies assist in the investigation, the responsibility for investigating child abuse rests with DFS. The Delaware Code specifies when DFS and law enforcement conduct joint investigations.

DFS investigates to determine if abuse, neglect, or dependency has occurred or is likely to occur; the level of harm or risk to the child; the capacity, ability, and willingness of the family to resolve the risk to the child; and whether court intervention is needed to protect the child.

Scope of Services

If it is determined that a child is at risk and the family needs ongoing services from DFS, treatment services begin and a family service plan is developed with the family. DFS can provide a variety of services to the family through the DFS case worker or through contracted agencies which include, but are not limited to :

- parenting skills education
- in-home parent aide services
- parenting support groups
- protective day care
- respite care
- family support counseling
- intensive home-based services
- substance abuse evaluation and treatment
- emergency funds to prevent placement
- foster care placement
- permanency planning

III. CONFIDENTIALITY

The Division of Family Services and the Division of Public Health agree to exchange client/family information on families and children served by either Division in instances where information exchange is in the best interest of families or children needing or requesting service from either Division.(29 Del. C. §.9016)

It is understood that information exchanged by either Division shall be restricted to client/family record reports and documents clearly pertinent to the family's and/or child's needs or problems. Further, any information exchanged shall only be used to facilitate efficient and timely evaluation, the provision of services and/or resolution of patient/client needs. Each Division assures that the confidential character of exchanged information will be preserved and, under no circumstances, will exchanged information be shared with any agency, program or person not party to this agreement without the express written consent of the family, child - if of age to consent or by the authority of Family Court.

No information in any form can be exchanged about drug or alcohol abuse treatment or sexually transmitted disease information without specific written consent for this information. Information about HIV testing or HIV status can only be shared with a specific consent or if the Division of Family Services holds legal custody of that child, and the information is necessary to provide to the child's caretaker.

The mechanism for the exchange of written information is:

A. DIVISION OF PUBLIC HEALTH

- A *Division of Public Health Consent to Release Information* (Appendix B) or the Interagency Confidentiality Agreement must be signed
- The release will specifically mention the Division of Family Services
- The Division of Family Services will receive a copy of the signed release

B. DIVISION OF FAMILY SERVICES

- A *Division of Family Services Consent to Release/ Obtain Information Form* (Appendix C) or the Interagency Confidentiality Agreement (Appendix D) must be signed
- The release will specifically mention the Division of Public Health
- The Division of Public Health will receive a copy of the signed release

IV. WORKING COLLABORATIVELY

When a case is opened by either agency, it is in the best interest of the child to identify all agencies currently involved with the family to avoid duplication and provide comprehensive services. This may be accomplished through:

- Interviewing the family
- Calling the other agency and requesting information about a family's activity status
- Utilizing appropriate client information systems (FACTS or CHCIS)

If both agencies are active, steps should be taken to initiate joint visits and joint service planning as described in this MOU.

V. REFERRAL PROCEDURES BETWEEN AGENCIES

A. DPH REFERRALS TO DFS

1. Cases to Refer to DFS

DPH is required by Delaware law to refer any case in which a child, ages birth to 18, has been or is suspected of being abused or neglected by a parent or caretaker. In addition to physical abuse, sexual abuse or neglect, DPH will refer the following:

- Infants defined as high-risk per the DFS High-Risk Infant Referral Protocol (Appendix G).
- Medical neglect cases where the result will be life threatening or lead to severe or long-term impairment. This shall include but is not limited to refusing to use prescribed apnea monitors, not receiving routine medical care for children with such diseases as sickle cell, immune deficiency, cystic fibrosis, and chronic lung disease. Failure of a well child to receive routine medical care is not considered medical neglect.
- A child residing with a non-relative caretaker for an indefinite period of time
- Any child whose sole caretaker is unable to provide adequately for him/her self (e.g. severe mental illness, retardation)
- Any infant born with a positive drug screen or born to a mother with a positive drug screen at delivery (Appendix E: DFS Substance Abuse Policy)
- Any child residing in an environment which places that child in immediate physical danger

The following types of cases should be referred to DFS if there is also an issue of abuse or neglect: (Appendix E: DFS Substance Abuse Policy)

- Substance abuse which contributes to abuse or neglect. Substance abuse, in and of itself, is not child abuse or neglect, except at the birth of an infant, as above.
- DFS will intervene on AIDS/ terminal illness cases only when the family abandons or rejects the child, maltreats the child or the child becomes dependent due to the death of the parent
- Any child whose family has no shelter and is unable or unwilling to take advantage of shelter opportunities offered to them

2. Procedures for Referral To DFS

The Child Abuse and Neglect Report Line(The Hotline) shall be used to refer each incident of suspected abuse, neglect, or dependency. Newly identified instances of abuse and neglect or events and observations which significantly alter the status of an active case should also be reported directly to the DFS Report Line. A verbal report must be made immediately.

- a. All reports to DFS should be made to:

1-800-292-9582

A Mandatory Reporting Form (Appendix F) should be faxed to the appropriate DFS regional office by the end of the next working day

New Castle County(Elwyn/University Plaza/Hotline)	Fax - 577-5515
Kent County	Fax - 739-6236
Sussex County	Fax - 856-5062

- b. The DPH caller will be informed by the Report Line staff what action will be taken.

B. DFS REFERRALS TO DPH

1. Cases to Refer to DPH

- Any infant receiving repeated medical attention for the same untreated life impairing or life threatening condition (Appendix G: DFS High-Risk Infant Referral Protocol)
- Any infant medically diagnosed as non-organic failure to thrive
- Any infant who has had a sibling die or was seriously injured as a result of child abuse or neglect, if the death or neglect was directly related to a health condition
- Any child, birth to three years of age who is known to have or is suspected of having a developmental delay or who has an established condition which places the child at risk for developmental delay (Appendix H: Protocol for Referrals to Child Development Watch)
- Any pregnant adolescent or woman not currently receiving prenatal care through another provider
- Any child or family with children, birth to age 21 years, will be accepted based on the facts, observations, and symptoms relayed in the referral. These may include cases in which the caregiver's parenting skills, lack of hygiene, safety, feeding, nutrition, or child's medical condition is negatively impacting the child's welfare.

2. Procedures for Referral to DPH

All referrals for home visitation and care management by PHNs, multidisciplinary developmental assessment and service coordination through Child Development Watch (Part H) should be referred through DPH Central Intake:

New Castle County -	1- 800 - 671- 0050/ 995-8617
Kent / Sussex County -	1- 800 - 752- 9393/ 422-1335

If there is another nursing service (School Nurse, VNA or other home health care agency) providing care for the family/child, they should indicate this is the referral to DPH.

Infants and children needing routine well child assessments, immunizations, or screening should be referred to their primary care provider. If the child does not have a primary care provider, they may be referred directly to a Public Health Clinic for services or for referral. Appointments can be made by calling directly to the clinic nearest to the family's home. (Appendix A)

VI. RESPONSE TO REFERRALS

A. DPH REFERRAL SCREEN

When DFS refers a family to DPH, the following procedures will be initiated:

- Based on the information obtained at time of referral, DPH will determine if the risk to the child is significant (in need of medical attention) or low to moderate risk
- For any child at significant risk, i.e., needing immediate medical attention, DPH will advise that the child be taken to the hospital or private physician
- All referrals to DPH from DFS will be reviewed by Team Leader or designee and care managers will be assigned to accepted cases
- If the referral is not accepted the Team Leader will contact the DFS case worker to inform them of the decision in a timely manner

A multidisciplinary team is the care model used by DPH. This team typically consists of a nurse, nutritionist, social worker, and if necessary, a physician. A DPH care manager will be identified on this team to work directly with the DFS case manager.

B. DFS REFERRAL SCREEN

The following procedures will be initiated by Investigation or Protective Treatment, as appropriate:

- The referral is taken by the Report Line, and a supervisor will screen for acceptance
- If accepted, a determination will be made as to whether the report is urgent (response within 24 hours) or routine (response within 10 calendar days) based on the risk to the child

- The referral is assigned to an Investigation case worker. If the case is already in Protective Treatment, an investigation worker will be assigned the new report
- If the referral is not accepted, report line staff will inform the reporter of the decision in a timely manner
- If the case is already active in Protective Treatment, the Treatment Worker will receive the reported information regardless of whether a new investigation is initiated.

C. DPH & DFS RESPONSE TO ACCEPTED REFERRALS

After a referral has been accepted by either agency, the reporter should be contacted prior to contacting the family when possible. The following should be discussed:

- Is the information on the referral correct and complete?
- Should both agencies meet the family together?
- Are there safety issues for either the DFS case worker or DPH staff?
- Is there a need for high-risk infant discharge planning? (Appendix G: DFS High-Risk Infant Protocol)

1. Urgent/Significant - High Risk

If the case is designated as an urgent response (within 24 hours) by DFS, the following should occur:

- DFS will visit the family within 24 hours; DPH may accompany the DFS worker on this visit, if appropriate, or may visit separately but do so in a timely manner
- The purpose of this visit is to assess the safety of the child(ren) and risk in the family, the appropriateness of the referral, and the immediate needs of the family
- It may be necessary for the DFS worker to negotiate a written/signed safety plan with the family.(Appendix I: Safety Plan) Under certain circumstances DPH may be part of the written safety plan, but in any case, DFS should inform DPH of the elements included in the safety plan.
- If the response to the referral is separate, then communication between the DFS case worker and the DPH care manager shall occur by the next working day to discuss initial findings and elements of the safety plan, if applicable.

- A verbal plan of next steps, services, and responsible agencies will be developed between DFS and DPH and documented in the case record
- Frequency of communication between the agencies during the assessment phase shall be determined and documented in the case records. Communication will minimally occur when major changes are being considered (discharge, transfer, closure, placement)
- Routine case information will be communicated directly to the involved DFS case worker or supervisor and the DPH care manager or supervisor
- Newly identified instances of abuse and neglect or events and observations which significantly alter the status of an active case should be reported directly to the DFS Report Line

2. Routine/low-moderate risk

If the case is designated as a routine response (within ten calendar days) by DFS or if the risk to the child is moderate or low, the following should occur:

- A joint or separate visit to the family shall be made within 10 calendar days
- The purpose of this visit is to assess the needs/risk in the family, the appropriateness of the referral, and the immediate needs of the family
- It may be necessary for the DFS worker to negotiate a written/signed Safety Plan with the family(Appendix I: Safety Plan). Under certain circumstances, DPH may be part of the written Safety Plan, but in any case DFS should inform DPH of the elements included in the plan.
- If the response to the referral is separate, then communication between the DFS case worker and the DPH care manager shall occur by the next working day after each agency has visited the family to discuss initial findings, and the elements of the safety plan, if applicable.
- A verbal plan of next steps services, and responsible agencies will be developed between DFS and DPH and documented in the case record
- Frequency of communication between the agencies during the assessment phase shall be determined and documented in the case records. Communication will minimally occur when major changes are being considered (discharge, transfer, closure, placement)
- Routine case information will be communicated directly to the involved DFS case worker or supervisor and the DPH care manager or supervisor

- Newly identified instances of abuse and neglect or events and observations which significantly alter the status of an active case should be reported directly to the DFS Report Line

VII. TREATMENT/ ONGOING CASE WORK

A. JOINT CASE PLANNING / JOINT HOME VISITS

After a case has been transferred to treatment within DFS, the new DFS case worker has approximately six weeks to complete a more thorough family assessment and develop a service plan with the family. During this period, the DFS case worker and DPH care manager will have sufficient communication to ensure that information is shared and that interim services are coordinated, provide safety to the children, and meet the family's needs. This contact may include telephone conversations, e-mail, or joint client visits.

Prior to the development of the service plan, the DFS case worker and the DPH care manager will meet to discuss:

- The progress of the family
- Continuing concerns
- The roles of both agencies
- DFS High-Risk Infant Referral Protocol (Appendix G)

A service plan agreement written on the DSCYF Service Plan Agreement form (Appendix J: Case Plan) will be developed. The Agreement establishes a formal written case plan which will include:

- Timing and number of face to face contacts with the family
- Needed referrals
- Expected results of services
- Time frames for accomplishments
- Specific agency responsibilities
- Case coordination / conferences
- Need for joint visits

In all jointly held cases, the DFS case worker will be responsible for monitoring and coordinating the implementation of the Service Plan Agreement and will be the primary case manager unless otherwise agreed upon.

The Service Plan Agreement shall be reviewed on a regular basis. At least once every three months, the DFS case worker and the DPH care manager will meet to review the plan and make any necessary changes.

Prior to closure, it is expected that the DFS case worker and the DPH care manager will have sufficient contact to ensure that services are coordinated and meet the needs of the family.

B. CASE DISPOSITION

A jointly held case will be closed only after joint discussion by DFS and DPH. Each agency will consider and respect the responsibility of the other, as mandated by law, to achieve consensus.

By DFS policy, an internal review system has been established to review family cases when risk has not been reduced and services have not been successful. Through this multi-function review, a decision is made whether or not DFS should close the family's case. The criteria are cases where the caseworker has worked with the family for at least six months and reasonable attempts to engage the family have not been successful. Among other things, DFS determines whether:

- Other agencies or support systems are in place that have regular contact with the child
- Those agencies or supports would report suspected child abuse or neglect

The DFS case worker will discuss the possibility of closure with DPH and review joint service plans. The position of the DPH care manager will then be shared with the review group.

C. DISPUTE RESOLUTION

If at any point during the delivery of services consensus is not reached, a case conference should be scheduled which includes management staffs of both DFS-DPH starting at the lowest previously uninvolved level. For example, if the initial case conference only included staff at the worker level supervisors should then be included to help achieve consensus. If consensus is not reached, respective agency liaisons should be contacted to resolve issues, identify barriers, and achieve consensus. (Appendix K: Chain of Command, and L: Division Organization Charts.)

VIII. COORDINATION BETWEEN AGENCIES

A. ROLE OF LIAISONS

A liaison will be assigned in each region for DFS by the Regional Administrators and DPH by the County Administrators.

The liaison will be responsible for:

- Resolving issues and negotiating system barriers
- Clarifying the content of the MOU
- Facilitating ongoing training
- Monitoring the effectiveness of the MOU and identifying necessary revisions
- Forwarding staff phone numbers, when updates occur, at the direction of the DFS Regional Administrators and DPH County Administrators
- In addition, the DPH liaison will be available to DFS for consultation, with a back-up being the County administrator
- Providing information upon request

B. JOINT TRAINING

New Employee Training - Each Division will be available to provide training on the MOU for new employees. Whenever possible, new employees from both agencies should participate in the other agency's MOU training.

On-going training - Needs will be discussed and planned at least once a year at the yearly MOU Review. The training may include:

- New information
- An exchange of ideas
- Shared concerns

IX. ADMINISTRATION OF THE MEMORANDUM

This Memorandum will remain in effect until reviewed by by a joint committee of assigned agency liaisons, and other senior staff persons as designated by their agency. Changes will be made to keep the Memorandum current and to guarantee that the respective responsibilities of the Division are fulfilled in the most expeditious manner. The Memorandum may be reviewed and revised by request of either agency to meet changing needs and/or special situations.

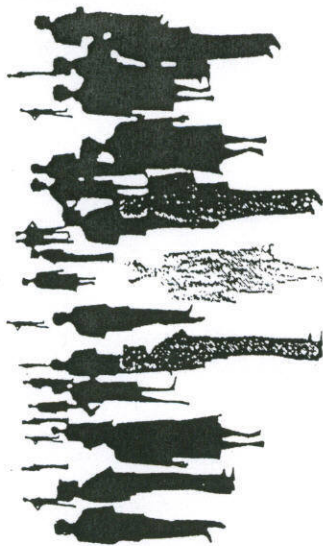
X. REVIEW BOARD

When a child jointly known to DPH and DFS is the victim of a serious injury or dies as a result of suspected or substantiated abuse or neglect, each agency will be responsible for notifying the other as to the occurrence of the incident. An analysis of the case will occur in accordance with DSCYF policy.

APPENDICES

- Appendix A Brochure of DPH Services and Sites for New Castle, Kent and Sussex Counties
- Appendix B DPH Consent to Release Information
- Appendix C DFS Consent to Release of Information Form
- Appendix D Interagency Confidentiality Agreement
- Appendix E DFS Substance Abuse Policy
- Appendix F Mandatory Reporting Form
- Appendix G DFS High-Risk Infant Referral Protocol
- Appendix H Protocol for Referrals to Child Development Watch
- Appendix I Safety Plan
- Appendix J Service Plan Agreement (Case Plan)
- Appendix K Chain of Command
- Appendix L Organization Charts for DFS and DPH

It's For You!



**PREVENTIVE
HEALTH SERVICES
IN
NEW CASTLE COUNTY**

Public Health Locations:

Belvedere State Service Center 301 Kiamensi Road Wilmington, DE 19804.....	995-8545
Delaware State Service Center 500 Rogers Road New Castle, DE 19720	577-2973
Hudson State Service Center 501 Ogletown Rd. Newark, De 19711.....	368-6840
Middletown Health Unit 214 N. Broad Street Middletown, DE 19709.....	378-5200
Northeast State Service Center 1624 Jessup Street Wilmington, DE 19802.....	577-3536
Porter State Service Center 511 W. 8th Street Wilmington, DE 19801.....	577-3515
Claymont Community Center 3301 Green Street Claymont, DE 19703.....	798-2430
West End Neighborhood House 710 N. Lincoln Street Wilmington, DE 19802	888-5478
Limestone Office 2055 Limestone Road Suite 201 Wilmington, DE 19808.....	995-8617

**PLEASE NOTE THAT SOME SERVICES ARE
NOT AVAILABLE AT ALL SITES**



**DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH**

Confidentiality

*What we say and do,
Is between us and you.*

The information you give us and the services we provide you are strictly confidential. No information will be given without your written consent.

If people you know work in our clinic and you don't want them to know you are our client, call us and we will help you make an appointment at a different clinic.

How much does it cost?

Fees vary according to your ability to pay.
Donations are accepted for all programs.

**Referrals to Medicaid
Managed Care**

Call or stop by any site for information and referrals or call Diamond State Health Plan Health Benefits Manager at 1-800-996-9969

STD Services

(Sexually Transmitted Disease)

Testing and treatment for: gonorrhea, syphilis, chlamydia, genital warts, and more.

For more information call Porter 577-3521

HIV Counseling and Testing

Free counseling and testing for the virus that causes AIDS. Confidential and anonymous testing available. For more information call:

Porter 577-3505, Hudson 368-6840, Middletown

378-5200, Northeast 577-3536 or the AIDS

Hotline 1-800-422-0429

Case Management For Persons with HIV/AIDS

Information and referral, coordination of services.

For information call Limestone - 995-8653

TB Prevention/Treatment Services

Screening and treatment for tuberculosis infection to clients of any age.

For appointment or more information call

Hudson - 368-6580 or Porter - 577-3502

Dental Services

Dental services to medicare covered prenatal clients and children ages 3-21.

For an appointment call the clinic nearest you, at Delawarr 577-2973, Belvedere 995-8545, Hudson 368-6840 or Porter 577-3404

Family Planning Services

Pregnancy testing, birth control, gynecological care and more. For appointment call Middletown 378-

5200, Northeast - 577-3536, or

Porter 577-3521

WIC Nutrition Program

Supplemental food benefits and nutrition education to pregnant and breastfeeding women, infants, and children under 5 years of age. Eligibility depends on income and nutritional need.

For the site nearest you call 1-800-222-2189

Child Health Services

Immunizations to clients of all ages, lead screening for children ages 0-5.

For an appointment call Claymont 798-2430

Middletown 378-5200, Hudson 368-6840, Porter 577-3515

Physical exams and developmental screening for those without insurance or family doctor. For an appointment call Hudson 368-6840, Porter 577-3515

Children's Eye Glasses

Annual optometric evaluation and eyeglasses as needed to kindergarten and school aged children.

Child must be without Medicaid and be financially eligible for free or reduced lunch program. For information call Hudson 368-6840

Disease Prevention Consultation

Information about lead poisoning, immunizations for children and adults, communicable diseases, & more.

For information call 995-8693

Public Health Nursing

Health teaching about pregnancy, infant care, needs of children

For more information call Limestone - 995-8617.

Medical Social Work

Medical social work services for children and pregnant women.

For more information call Limestone - 995-8617

Nutrition Counseling

Nutrition education and counseling.

For information call Limestone - 995-8617

Health Promotion Team

Consultation, technical and resource support to public/private sector and community health education programs. For more information call Limestone 995-8693

Psychological Services

Evaluation and intervention for parenting concerns such as discipline, behavior problems for children 0-5 years of age.

For information call Limestone - 995-8617

Child Development Watch

Assessment, intervention, service coordination for children 0-3 years with a disability and/or developmental delay.

For information call Limestone 995-8617

Hearing Clinic

Providing diagnostic and rehabilitative services to children aged 0 - 21 with known or suspected hearing loss or auditory perceptual problems. Medical consultation and hearing aids are provided as needed for clients who meet the financial criteria.

For an appointment call 856-5213.

Eye Clinic

Providing annual optometric evaluation and eyeglasses as needed to kindergarten and school aged children. Child must be without Medicaid and be financially eligible for free or reduced lunch program.

Referrals are arranged through school nurses.

Confidentiality

*What we say and do,
Is between us and you.*

The information you give us and the services we provide you are strictly confidential. No information will be given without your written consent.

If people you know work in our clinic and you don't want them to know you are our client, call us and we will help you make an appointment at a different clinic.

How Much Does It Cost?

Fees vary according to your ability to pay. Most services are free. Donations are accepted for all programs.

Public Health Clinical Locations:

Sussex County Health Unit.....856-5246
Georgetown State Service Center
544 S. Bedford Street
Georgetown, DE 19947

Edward Pyle State Service Center.....732-9501
P.O. Box 237
Frankford, DE 19945

Laurel State Service Center.....856-5223
Mechanic Street
Laurel, DE 19956

Lewes Public Health Clinic.....645-5815
1632 Savannah Road
Lewes, DE 19958

Milford State Service Center.....422-1327
11/13 Church Avenue
Milford, DE 19963

Shipley State Service Center.....628-2006
350 Virginia Avenue
Seaford, DE 19973

All services are not available at every location. For services based at a single location, a phone number is listed. Otherwise, call the clinic site nearest you for information or to make an appointment.

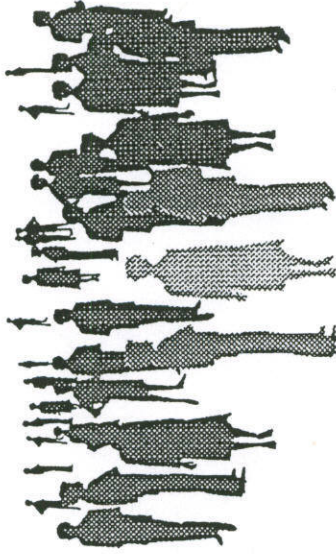


DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

Sussex County

Health Care

In



It's For You!

STD Clinic

(Sexually Transmitted Disease)

Providing free testing and treatment for: gonorrhea, syphilis, chlamydia, genital warts, and more.

Clinic Hours: Tu, W, Fri. 8 a.m. - 4 p.m.

For an appt., or more information call 856-5135.

HIV Counseling and Testing

Providing free counseling and testing for the virus that causes AIDS.

You must be at least 12 years old to have HIV testing done without parental consent.

For an appointment in any of the clinic sites call 856-5135.

Public Health Nursing

Providing education on maternal and child care management and health maintenance in the home setting.

For information call the clinic nearest you at Georgetown, Milford, and Seaford.

TB Clinic

Providing clients of any age with screening and treatment for tuberculosis infection.

For more information call the clinic nearest you at Georgetown or Milford.

Dental Services

Providing dental health services to Medicaid children ages 3-21.

Clinic Hours: Monday - Friday

For an appointment call the clinic nearest you at Georgetown, Milford, and Seaford.

Women's Health Clinic

Providing pregnancy testing, gynecological care and birth control.

Fees vary according to a sliding scale.

Clinic Hours: Mon-Fri.
Evening hours are available.

For an appointment call the clinic nearest you.

Prenatal Clinic

Providing comprehensive care for you and your baby during your pregnancy.

No insurance necessary. Medicaid is accepted. Your eligibility for Medicaid will depend on income.

For an appointment call the clinic nearest you at Lewes, Milford, Pyle and Seaford.

WIC Clinic

Providing supplemental food benefits and nutrition education to pregnant and breast-feeding women, infants and children up to and including age 5.

Eligibility depends on income.

Clinic Hours available at all sites.

For an appointment call 422-1343

Child Health Clinic

Providing physical exams, immunizations, education; screening, and referral to children ages birth to 21 years of age.

Clinic Hours: Monday - Friday

For an appointment call the clinic nearest you.

Medical Social Worker

Providing medical social services for clients that are being followed through the public health system.

For information call the clinic nearest you in Georgetown and Milford.

Environmental Health Services (Health Systems Protection)

Providing institutional, plumbing, food and water inspection.

For information call 856-5496.

Nutrition Counseling

Providing nutrition education, home visits and counseling to people of all ages.

For information call 628-2006

Adult Health

Providing screening for chronic diseases such as high blood pressure, cancer, and diabetes in men and women ages 35 and above. Donations are encouraged.

For an appointment call the clinic nearest you in Georgetown, Milford, and Seaford.

Health Education

Provides consultation, technical and resource support to public/private sector and conducts health educational programs in community settings.

For additional information or to schedule a program call Georgetown or Milford.

More Clinics

On The Next Page





STATE OF DELAWARE
DIVISION OF PUBLIC HEALTH
CONSENT TO RELEASE INFORMATION

Client's Name: _____ Birth Date: _____

I hereby give consent to the release of information about me and/or my minor child(ren) to or from the below listed person(s) or agency(ies):

FROM: _____

TO: _____

ATTENTION OF: _____

RECORDS REQUESTED: _____

If HIV test was done test results [] are to be included [] are not to be included in this release of information.

I understand that the information cannot be released from or issued to any person or agency that is not specifically listed above.

I have read and understand all of the above. All blanks have been filled in prior to my signature. My signature was given freely and voluntarily.

THIS CONSENT IS VALID UNTIL _____ (EXPIRATION DATE)

DATE

Signature

DATE

Witness (Representative)

Original Copy: Agency Releasing Information

Yellow Copy: File Copy

Pink Copy: Client's Copy

CH-25

DOC. #35-05-02/90/07/10

GAP-4

Appendix C

DIVISION OF CHILD PROTECTIVE SERVICES CONSENT TO OBTAIN/RELEASE INFORMATION

I, _____, hereby give consent for information about me/or my minor child, named _____ DOB: _____, to be released to or obtained from an authorized representative of the Division of Child Protective Services for the purposes of an investigation and/or planning regarding my children and/or me. Planning includes, but is not limited to, counseling, treatment services, medical services and education and training.

I understand that this information may be received from and/or issued to a number of sources, including but not limited to the following (please check):

- _____ Law Enforcement Agencies
- _____ School (Academic, Disciplinary/Personal, Medical)
- _____ Hospital (Medical and Social)
- _____ Medical Resources (including private physicians)
- _____ Public Health Clinic
- _____ Family Counseling Agencies
- _____ Mental Health Resources (including Delaware State Hospital, private physicians and counselors)
- _____ Drug and Alcohol Treatment Resources

Except (list any sources for which consent is not given): _____

This consent extends from this date for a period of (check one):

_____ 6 months (maximum) _____ other (specify) _____

This consent may be revoked by me in writing at any time; any information released prior to such revocation remains released in accord with this consent. I have read and understand all of the above; all blanks have been filled in prior to my signature. This consent was freely and voluntarily given.

Date

Signature

Date

Witness (D.C.P.S. Worker)

DOC: 37-02-001/83/08/07 Rev.11/1/92

APPENDIX D
STATE OF DELAWARE

INTERAGENCY CONSENT TO RELEASE INFORMATION

Sharing information helps agencies provide better services to my child/me and my family. The three departments listed below have entered into an agreement for the coordination of services and sharing of information. Only those agencies that are planning or giving services to me or my child may receive information. Any other agency that wants information about my child/me will get it *only* if I sign an agreement with that agency.

Shared information may include:

- child's/my full name • telephone number • address
- social security number • birthdate • parents' and brothers'/sisters' names

I understand that this form is not used to release information about drug and alcohol treatment, pregnancy, and sexually transmitted diseases.

I, _____, also allow all of the listed State of Delaware agencies to share the following information about my child/me, _____ (birthdate _____).

INFORMATION THAT MAY BE SHARED

Yes	No		Yes	No	
_____	_____	Admission Report	_____	_____	Occupational/Physical Therapy
_____	_____	Developmental Assessment	_____	_____	Evaluation
_____	_____	Discharge Report	_____	_____	Psychiatric Evaluation
_____	_____	Education Progress Report	_____	_____	Psychological Evaluation
_____	_____	Individual Education Plan	_____	_____	Service History
_____	_____	Individual Family Service Plan	_____	_____	Social History
_____	_____	Educational Evaluation	_____	_____	Speech Therapy Evaluation
_____	_____	Financial Eligibility (AFDC, Food	_____	_____	Treatment Progress Notes
_____	_____	Stamps, General Assistance,	_____	_____	Treatment Progress Report
_____	_____	Medicaid, etc.)	_____	_____	Vocational Evaluation
_____	_____	Medical History/Evaluation			

AGENCIES THAT MAY SEND/RECEIVE INFORMATION

Department of Health & Social Services		Department of Services for Children, Youth and Their Families	
Yes	No	Yes	No
_____	_____	_____	_____
	Division of Mental Retardation		Division of Child Mental Health Services
_____	Division of Public Health	_____	Division of Family Services
_____	Division of Social Services	_____	(Child Protective Services)
_____	Division of State Service Centers	_____	Division of Youth Rehabilitative Services
_____	Division of Alcoholism, Drug Abuse, and	_____	DSCYF Education Program
	Mental Health		
_____	Division of Management Services (Birth-		
_____	to-Three Program)		
_____	Division for the Visually Impaired		

Department of Public Instruction

Yes	No
_____	_____
	Local School Districts

AGREEMENT TO RELEASE

I agree to the interagency sharing of information. I can take away my permission at any time. I can also change it at any time unless the information has already been released. This permission is good for one year after I sign it.

Print Name _____

Signature _____

Date _____

Parent ☐ Guardian ☐

Legal Adult (18 years) ☐

REFUSAL TO RELEASE

I do not want to share this information with the listed agencies. I understand that my refusal will not keep me or my child from receiving appropriate services. My refusal will not be held against me.

Print Name _____

Signature _____

Date _____

Parent ☐ Guardian ☐

Legal Adult (18 years) ☐

ORGANIZATION'S AFFIRMATION

As the participating organization's representative, I affirm that I have reviewed this form and its use with the consenting person and that to the best of my knowledge he/she understands.

Witness _____

Date _____

Agency _____

TRANSLATOR'S STATEMENT

I have orally translated/read/signed the above into _____ (language). To the best of my knowledge, I believe the consenting person understands the nature and use of this form.

Translator's Signature _____

Date _____

Revocation Statement

I _____ (consenting person) take away the consent I gave to _____ (originating organization) on _____ (date). I understand that _____ (originating organization) will notify any participating organization to which information has been sent or from which information has been received.

Signature _____

Date _____

Witness _____

Date _____

Agency _____ Revocation letter attached (Yes/No) _____

- * The Interagency Consent to Release Information form is based on the Interagency Confidentiality Agreement for Accessibility in Data Sharing between Participating Organizations. This form may not be altered in any manner without written authorization from the State of Delaware Interagency Confidentiality Committee. This form may be photocopied for use by the participating organization.
- * The State of Delaware does not discriminate or deny services on the basis of race, religion, color, national origin, sex, disability and/or age.

F. Parental Substance Abuse	
<p>F-1. Because of the relationship between parental substance abuse and child abuse or neglect, the presence of substance abuse will always be assessed in determining safety and the need for protective services. When parental substance abuse is known or suspected, DFS will refer to a substance abuse treatment agency for evaluation and recommendations. Substance abuse is assumed to be present in all cases until such time that screening (either by DFS or a substance abuse treatment agency) specifically rules it out. This policy pertains to reports at any stage of activity with the Division, including those received by the report line, cases under investigation, open in treatment, or adoption.</p> <p>F-2. When a child comes into foster care and parental substance abuse is a risk factor, the child will not be returned to the parent(s) until a substance abuse evaluation has been completed and DFS has received the recommendations.</p> <p>F-3. With the exception of infants exposed prenatally, the Division of Family Services will only accept reports for investigation where there is an allegation of abuse, neglect, or dependency in addition to parental substance abuse.</p> <p>F-4. The Division of Family Services accepts for investigation all reports from medical facilities of infants exposed in utero to alcohol or drugs as evidenced by either the mother or infant testing positive for drugs at birth. The Division will not accept complaints of in utero exposure to alcohol or drugs during pregnancy, i.e. evidenced only by prenatal screenings. The response decision will be determined by careful consideration of the risk factors and danger loaded elements. Any report alleging prenatal exposure where the child is experiencing medical complications requires response prior to the child's release from the hospital.</p> <p>F-5. Regardless of whether or not substance abuse is mentioned in the Hotline report, the investigation caseworker will assess the use of substances during their interviews and in completing the investigation risk assessment.</p> <p>F-6. Safety planning must include careful consideration of the extent of drug/alcohol use and the impact on the parent's ability to keep the children safe.</p>	<p>Parental Substance Abuse Policies</p> <p>Intake</p> <p>Investigations</p>

Division of Family Services
Policy -- Administration

of substance abuse. This process will be utilized by caseworkers during all investigations regardless of whether or not substance abuse is indicated in the report. If the caseworker determines that parental substance abuse is not a significant risk factor, this is documented in the investigation risk assessment. If parental substance is a risk factor, the impact of the substance abuse will be considered in the investigation risk assessment and in safety planning.

- F-20. Evaluation by a substance abuse treatment professional can occur during investigation or during protective treatment services. The investigation caseworker and supervisor will determine if it is necessary to have an evaluation completed during investigation in order to develop an adequate safety plan or determine if ongoing services are needed.
- F-21. When a referral for a substance abuse evaluation is made, the caseworker will complete the FACTS Service Referral documenting the date the referral was made and the date services were initiated.
- F-22. Treatment caseworkers will continue to assess the possibility of parental substance abuse during the assessment process and in ongoing safety planning.
- F-23. If parental substance abuse is known to be or is suspected to be a significant risk contributor, the caseworker must arrange for an evaluation by a parental substance abuse treatment professional, unless completed during investigation or unless the parent(s) is already involved in a substance abuse treatment program. When a referral for a substance abuse evaluation is made, the caseworker will complete the FACTS Service Referral, documenting the date the referral was made and the date services were initiated.
- F-24. When parental substance abuse is indicated, family service plans must focus on behavior related to substance abuse and parenting. Substance abuse treatment will be an integral service in all such family service plans.
- F-25. Toxicology screens may be useful in determining the extent of use and recovery. They should be seen as a part of therapeutic efforts and not a replacement for services and supports to protect the child and strengthen the family. A positive toxicology screen should establish the need for a further, more comprehensive assessment of the family's strengths and needs and of the potential risk of the child.
- F-26. Toxicology screens should be used during participation in a substance abuse treatment program. Where appropriate, DFS caseworkers will obtain funds or utilize contracted services to pay for Toxicology screens

Treatment



INSTRUCTIONS: Any physician, and any other medical person in the healing arts including any person licensed to render services in medicine, osteopathy, dentistry, any intern, resident, nurse, medical examiner, school employee, social worker, psychologist, or any other person who knows or reasonably suspects child abuse or neglect shall make a oral report to the Report Line using the number at the top of this page in accordance with 16 Del. C., Ch. 9, par. 904.

Within 72 hours after the oral report, send a completed Child Abuse/Neglect Mandatory Reporting Form to the regional office of the county of the child(ren)'s residence. Please **type or print** the information and sign the form on the back.

NEW CASTLE COUNTY:

Division of Family Services
NCC Police Department
3601 North DuPont Highway
New Castle, Delaware 19720

KENT COUNTY:

Division of Family Services
James Williams State Service Center
805 River Road
Dover, Delaware 19901

SUSSEX COUNTY:

Division of Family Services
Georgetown State Service Center
546 South Bedford Street
Georgetown, Delaware 19947

IDENTIFYING INFORMATION

Child's Name (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Victim (Yes/No)
--	-----------------------	-----	------	--------------------

1.

Current Address:

2.

Current Address:

3.

Current Address:

4.

Current Address:

5.

Current Address:

Parents'/Custodians'/Caretakers' Names (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Perpetrator (Yes/No)
--	-----------------------	-----	------	-------------------------

Mother

6.

Current Address:

Father

7.

Current Address:

Custodian/Caretaker (Relationship)

8.

Current Address:

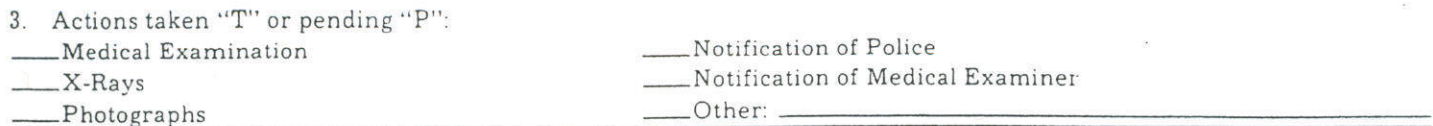
Please specify for numbers 1 - 8 above:

Foreign language spoken: #'s _____ Specify: _____

Handicapping conditions: #'s _____ Specify: _____

2. If applicable, note the exact location of any injury by placing a number on the model below. Use the lines to the right of the models to describe the corresponding injury that each number represents. Check the category of injuries below:

☐ Physical Abuse ☐ Sexual Abuse ☐ Physical Neglect.



Prior DFS Case Activity/Reports? ☐ Yes ☐ No; If yes, specify dates: _____

APPENDIX G
DFS High-Risk Infant Referral Protocol

STATEMENT OF PURPOSE:

Planning for the hospital discharge of the high-risk infant as defined below is the domain of the Division of Family Services and is necessary to assure a safe environment when the infant leaves the hospital setting. This document defines the lead role of the Division of Family Services (DFS) and the multi-agency collaborative nature necessary when planning for the high-risk infant's hospital discharge.

The discharge planning process should be done utilizing a team approach to include the development of the DFS Safety Assessment and Interdivisional Service Plan (ISP) with clearly defined time frames and responsibilities for all team members. This team could include, as appropriate, DFS, hospital staff, a member of an apnea monitor team, home health care agencies, the Division of Public Health (DPH), and the infant's family. DFS will assume the lead position and in that capacity, will be responsible for the coordination of services as they pertain to planning for the infant.

Definition of High Risk Infant:

1. An infant is considered to be 0-1 year of age. The high-risk infant is one who has or is at increased risk for a chronic physical, developmental, behavioral or emotional condition that requires health and related services of a type or amount beyond that required by children generally. Additionally, the family is unable or unwilling to provide or ensure the necessary care.
2. When appropriate, these guidelines would also apply to the child over one year of age

CRITERIA:

Refer to High Risk Infant Criteria to determine if child or family meets criteria for a High Risk Infant Discharge Planning Meeting,

SCOPE:

This protocol applies to the DFS social workers, Division of Public Health nurses and social workers, and other healthcare professionals deemed necessary by DFS to provide social and medical support to the infant immediately after hospital discharge.

GOAL:

It is the goal of this protocol to develop comprehensive discharge plans for all infants determined to be high-risk who are also currently active with DFS or whose case has been accepted by DFS for investigation. By developing a comprehensive discharge plan with all parties involved, the parties will be clear as to their own roles and expectations as

APPENDIX G (con't)

well as whom to contact in the event that questions or concerns arise. The focus of the comprehensive discharge plan should stay focused on the needs of the high-risk infant.

APPLICATION:

Discharge planning for the high-risk infant is the lead responsibility of the assigned DFS social worker. As stated above, the overall goal of this process is to assure that the high-risk infant is discharged into an environment that is safe and supportive of the infant's medical needs. The following guidelines are a framework for practice and are implemented by the DFS social worker and/or other providers identified as part of the plan of care.

GUIDELINES FOR CONVENING A HIGH RISK INFANT DISCHARGE PLANNING MEETING:

1. Hospital staff review the High Risk Infant Criteria to determine if the infant or their family meet at least one * item OR combination of factors contained in the High Risk Infant Criteria that lead the Health Care Provider to believe that the infant is at risk of abuse, neglect or dependency.
2. Hospital Health Care Provider will call the DFS Hotline to make a referral. If the referral is accepted for investigation or if the case is already active with DFS, the Hospital Health Care Provider will request a High Risk Infant Discharge Planning Meeting
3. The Hospital Health Care Provider will coordinate the meeting prior to the infant's discharge. The meeting should include the family, the Hospital Health Care Provider and the assigned DFS social worker. Any other agency involved in the care or monitoring of the infant upon discharge (i.e., home healthcare agencies) should be invited to the discharge meeting as well.
4. The Division of Public Health will participate in the meeting if they are already involved with the family or are invited by DFS and the family agrees to their participation.
5. The Hospital Health Care Provider will make every effort to provide at least 24 hours notification to all participants of the date, time and location of the meeting.
6. At the conclusion of the meeting, a plan will be developed to outline the roles and responsibilities of all parties involved as well as whom to contact in the event that concerns or questions arise. The DFS social worker and the DPH nurse should document this information in the Interdivisional Service Plan when applicable.
7. The DFS social worker should be notified of the date and time of discharge.
8. Home visits will be conducted by the DFS social worker as well as any other party identified at the discharge planning meeting according to the established discharge plan.

* Hospital Health Care Providers responsible for this activity can include social workers, nurses, case managers, physician and others defined by the organization as responsible for such activities.

APPENDIX G (cont.)

SAI	Medical Factors	SAI	Parental Factors	SAI	Social/Environmental Factors
*	Meets part C eligibility	*	Substance abuse which is directly related to the abuse or neglect.		No heat during cold months, no electricity and/or plumbing and family has no place else to go.
	Substance Abuse Screenings are positive for mother and/or child on any/all substances		Diagnosed mental health issues in which the parents are not following through with treatment-resulting in abuse or neglect of child or which has a great risk of resulting in the abuse or neglect of a child		No food and no food stamps that arrive within the next few days (a food closet referral ineffective) there is no real reason why parents have not fed their children.
	Technology involved to be considered with other social, environmental, parental factors.	*	A current report of physical or sexual abuse		Dirty housing that poses a health (exposed live wiring, feces, mold) and no nearby and helpful relatives resources or friends.
	Medical equipment, such as apnea monitor, tube feeding, oxygen equipment		Parents who flee from services in other states when their case was founded	*	No housing after having exhausted existing resources, friends and
	One or more unexplained infant deaths		Felony level domestic violence in which children are witness.	*	No resources for infant
	Non-organic FTT		Two or more infant deaths in the same family		Social support needed for care not available
	Non-compliance with Medical Treatment Plan results in readmissions	*	Other children in placement, or not living with parents, and active w/DFS		Family refuses voluntary community support services
	Any other situation that would meet the requirements for a mandated report		parents do not follow through with pre-discharge plan of care		Lack of Bonding - Parent refuses unable to provide care
		*	Felony level domestic violence that triggers delivery of infant		The family is not part of a religious group that prohibits medical intervention or is refusing treatment that will result in death or disability.
			Family violence among household members while infant is hospitalized		Referral to DFS has been accepted investigation by the supervisor or DFS Hotline.
			Either parent appears under the influence while in contact with hospital personnel		
		*	Parent non-compliance with Discharge Planning		
			Lack of Bonding		
			"Bizarre" behavior during hospital stay?		
		*	Parents have demonstrated incapable of following Discharge Plan		
		*	Currently active w/DFS		
		*	Violence that precipitated birth		

APPENDIX H
Division of Family Services'

PROTOCOL FOR REFERRALS

To

Child Development Watch

1. DFS Family Service Specialists will utilize a variety of developmental checklists and charts provided as resource tools during the DSCYF-DFS Part C training sessions, as well as the three-page definitions approved by the Interagency Coordinating Council to identify within individual Investigation and Treatment caseloads all children with suspected established conditions and/or developmental delays.
2. DFS Family Service Specialists will contact the parent(s) of a potentially eligible Part C child to discuss available Part C services, which include the multidisciplinary assessment by Child Development Watch, and to give them Part C literature; preferably, a face-to-face meeting will occur.
3. DFS Family Service Specialists will encourage the parent(s) of a potentially eligible child to refer the child to Child Development Watch by calling DPH Central Intake in New Castle County at Limestone Road at 995-8617 or 1-800-671-0050 or DPH Central Intake in Kent and Sussex Counties in Milford at 422-1335 or 1-800-752-9393.
4. DFS Family Service Specialists will discuss with the parent(s) of a potentially eligible child the need for a referral to Child Development Watch. In situations in which it is not likely that the parent(s) will make the referral, the DFS Family Service Specialists will make the referral to Child Development Watch.
5. When DFS Family Service Specialists make the referral to Child Development Watch, the following information will be disclosed to the DPH staff members taking the telephone referral if it is known to DFS:

Child's Name, MCI Number, Address, Phone Number, Birthdate, Gender, Race, Private Insurance Company Name, Medicaid Number, Reason for Referral, Pertinent History (i.e. Developmental Screening, Previous Assessment, Diagnosis), Other Agencies Involved (If available: Birthweight, Date of Admission, Date of Discharge, Discharge Weight, Drug Exposure, APGAR Scores, Length of Gestation, Apnea Monitor, etc.)

APPENDIX H (con't)

Mother's Name, Birthdate, Phone Number

Father's Name, Phone Number, Address if Different Than Mother's

Guardian's Name, Phone Number (If Other Than Parent)

Primary Physician's Name, Phone Number

DFS staff will document in the Significant Events section of the case record that the referral was made and who made the referral.

6. CDW will accept and triage for multidisciplinary team assessment the telephone referrals from parent(s) and DFS Family Service Specialists. DFS will not seek additional health information from the family if it is not relevant to the DFS case plan. The referrals are made with a DFS staff member's professional opinion (a pre-screening) that further evaluation is indicated. CDW Service Coordinators will notify DFS of family-initiated referrals in cases involving families active with DFS.
7. CDW will follow its routine team procedures, i.e. assessment, assignment to Service Coordinator or to field nurse, if applicable, completion and implementation of the Individualized Family Service Plan, etc. DFS Family Service Specialists will be made aware of the status of the referral and outcome of the assessment and will be encouraged to participate in the development of the IFSP as authorized by the family.
8. DFS will provide written documentation as requested to CDW with written consent by the parent(s) for the release of information. CDW will provide written documentation as requested to DFS with written consent by the parent(s) for the release of information.
9. The DFS Liaison to Part C will monitor the referral process and solicit feedback from DFS and CDW staff in ascertaining the feasibility of the process and the need for revision.

APPENDIX I

CASE NAME: _____

FACTS CASE NUMBER: _____

DATE OF HOTLINE REPORT: _____

WORKER NAME: _____

PURPOSE: To help assess whether any children are likely to be in immediate danger of serious harm, and to determine what interventions should be maintained or initiated to provide appropriate protection.

INSTRUCTIONS: Complete Sections 1 and 2 of this form during the initial face to face contact with the family. A Safety Plan (Section 1) should be developed whenever the Safety Decision (Section 2) indicates a child is unsafe.

SECTION I

PART A: SAFETY FACTOR IDENTIFICATION

Directions: The following list of factors are behaviors or conditions that may be associated with a child being in immediate danger of serious harm. The information will be based on your interviews and observations. Identify the presence or absence of each factor by checking either "yes" or "no." It is mandatory to check one box for each factor. Complete one safety assessment per household.

1. YES ☐ NO ☐ Caretaker's behavior is violent or out of control.
2. YES ☐ NO ☐ Caretaker describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.
3. YES ☐ NO ☐ Caretaker caused, or has made a plausible threat, that has or would result in serious physical harm to the child.
4. YES ☐ NO ☐ Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee or refuses access to the child.
5. YES ☐ NO ☐ Caretaker has not, or will not provide sufficient supervision to protect child from potentially serious harm.
6. YES ☐ NO ☐ Caretaker has not, or is unable to meet the child's immediate needs for food, clothing, shelter, and/or medical care. (Consider if the child has special needs.)
7. YES ☐ NO ☐ Caretaker has previously abused or maltreated a child, and the severity of the abuse or maltreatment, or the caretaker's prior response to the incident, suggests that child safety may be an immediate concern.
8. YES ☐ NO ☐ Child is fearful of people living in or frequenting the home.
9. YES ☐ NO ☐ The child's physical living conditions are hazardous and may cause serious harm.
10. YES ☐ NO ☐ The caretaker cannot/does not explain injuries or conditions.
11. YES ☐ NO ☐ It appears that the caretaker's drug or alcohol use, mental illness, or developmental disability seriously affects his/her ability to supervise, protect, or care for the child.
12. YES ☐ NO ☐ Domestic violence appears to seriously affect the caretaker's ability to supervise, protect, or care for the child.
13. YES ☐ NO ☐ Complainant alleges or perpetrator acknowledges criminal history which puts the child at risk.
14. YES ☐ NO ☐ Maltreating caretaker exhibits no remorse or guilt.
15. YES ☐ NO ☐ Other (specify) _____

If no safety factors are present in the "yes" column, proceed to Section 2: Safety Decision.

PART B: SAFETY FACTOR DESCRIPTION

Directions: For all safety factors which are checked "YES," note the applicable safety factor number and then briefly describe the specific individuals, behaviors, conditions, and/or circumstances associated with that particular safety factor.

SECTION 2: INITIAL SAFETY DECISION

Directions: Identify your safety decision by checking the appropriate box below. (Check one box only.) This decision should be based on the assessment of all safety factors and any other information known about this case.

A. Unsafe: ☐ Without a controlling intervention(s), one or more children will likely be in immediate danger of serious harm. You must complete Section 3.

B. Safe: ☐ There are no children likely to be in immediate danger of serious harm.

SUPERVISOR'S NAME: _____ **DATE OF SUPERVISORY REVIEW:** _____

SECTION 3: SAFETY PLAN

Directions: For each safety factor checked in Section 1, identify the safety interventions taken or planned to control each factor and explain how each intervention protects each child. The plan should explain who will be responsible for the intervention, the parties involved, and address time frames. In addition, the DFS caseworker should state how and when the plan will be monitored.

Sample plan: Safety factor - Parent #1 threatens to harm the parent #2 during visits with the child.
Intervention - Parent #1 will visit the child at the Supervised Visitation Center.
Responsibility - DFS caseworker will refer family to the Supervised Visitation Center by (date). Parent #2 will transport the child to the Supervised Visitation Center each Saturday at (time). Parent #1 will abide the supervised Visitation Center rules and pay for this service.
Time frame - This plan is effective for 90 days.
The DFS caseworker will contact the Supervised Visitation Center monthly to monitor.

WHEN THERE IS AGREEMENT, ALL PARTIES SHOULD SIGN THE SAFETY PLAN AND DATE THEIR SIGNATURES. EACH PARTY SHOULD RECEIVE A COPY OF THE SAFETY PLAN.

CASE NAME:

FACTS CASE NUMBER:

SAFETY PLAN

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

SIGNATURES/DATES

The Division of Family Services has identified child safety issues in your family and a Safety Plan has been developed with your participation. Your signature indicates you will comply with the Plan. Failure to comply with the Plan by any signatory may require legal action by the Division to protect the child(ren).

Caseworker	_____	Date Completed	_____
Parent/Custodian	_____	Date Completed	_____
Parent/Custodian	_____	Date Completed	_____
Other (specify)	_____	Date Completed	_____

SUPERVISOR'S NAME: _____ DATE OF REVIEW & INITIALS: _____

RIGHT TO APPEAL/REQUEST A FAIR HEARING

The Division of Family Services acknowledges and supports a party's right to appeal when that party is directly impacted by the following critical decision points: approval/disapproval, casework decision/case plan, and determination of eligibility. If you wish to appeal, please send a written request to your case worker's supervisor within thirty calendar days of official notification of the decision. If you do not know the supervisor's name, the name will be supplied to you upon request of the Division caseworker. The request for an Appeal Hearing should explain the reason(s) for the request and the relief requested.

If you feel you have been treated unfairly due to age, race, religion, ethnicity, gender, sexual preference, or disabling conditions, contact the Delaware Office of Human Relations or the United States Office of Civil Rights to file a complaint and to request a Fair Hearing.

DISTRIBUTION:

White	-	Parent/Custodian
Yellow	-	Parent/Custodian
Pink	-	Other Plan Participant
Golden	-	DFS Case File

APPENDIX J

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

SERVICE PLAN AGREEMENT

Name of Child and Family	DOB	Case #	Date of Plan
--------------------------	-----	--------	--------------

Case Active With:

() DCPS () DYRS () DCMH () YDC () Other: _____

Primary Case Manager: _____

Service Plan Goal: _____

Services Required: (Cite agency document describing details of the plan; if not available, complete Implementation Plan and attach)

Agency

Agency

// Assessment Services _____ // Housing _____

// Counseling for Child _____ // Employment _____

// Counseling for Family _____ // Education _____

// Financial Assistance _____ // Placement _____

// Transportation _____ // Ind.Liv. _____

// Other (Specify) _____

// Other (Specify) _____

// Other (Specify) _____

I have read this service plan, including pages 2 through _____. I know I can attach a signed statement outlining any disagreement I have with this plan. I know that if I sign below, I am agreeing to cooperate in the implementation of this plan.

Participants to Service Plan Agreement:

Signature/Title	Signature/Title
-----------------	-----------------

Signature/Title	Signature/Title
-----------------	-----------------

Signature/Title	Signature/Title
-----------------	-----------------

Review Date: _____

APPENDIX J (con't)
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
IMPLEMENTATION PLAN

Page _____ of _____

Name of Child	DOB	Case #	Date of Plan
---------------	-----	--------	--------------

Service Required _____

OBJECTIVE: _____

ACTIVITIES: _____

Person/Agency Responsible: _____

Expected Results: _____

Date to Accomplish: _____

Date Completed: _____

OBJECTIVE: _____

ACTIVITIES: _____

Person/Agency Responsible: _____

Expected Results: _____

Date to Accomplish: _____

Date Completed: _____

APPENDIX K
Direct Service Table of Operation

Chain of Command

DFS

Carlyse Giddins
Division Director

Laura Miles
Deputy Director

Candace Charkow
Office of Children's Services

Shirley Roberts
NCCo Regional Administrator – Elwyn

Carla Benson-Green
NCCo Regional Administrator – University Plaza

Ione Truesdale
Kent County Regional Administrator

Van Warrington
Sussex County Regional Administrator

Assistant Regional Administrator

Supervisor

Case Worker

DPH

Ulder Tillman, M.D., MPH
Division Director

Barbara Jarrell-Krausz
Deputy Director

Jacqueline Christman, M.D.
Section Chief
Community Health Care Access

Anita Muir
Administrator
New Castle County

Barbara DeBastiani
Administrator
Kent and Sussex Counties

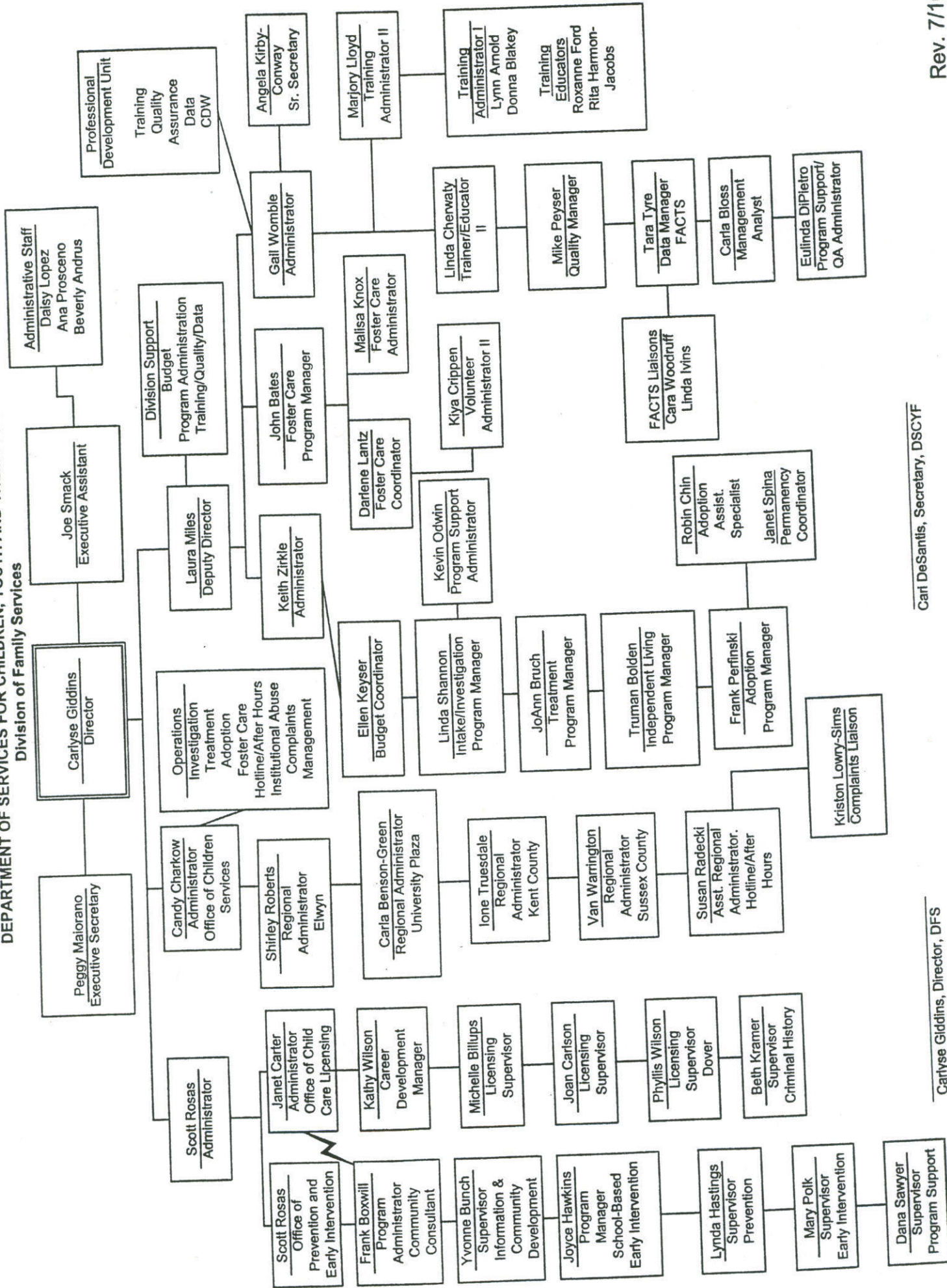
Manager

Team Leader

Care Manager/Nurse

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

Division of Family Services



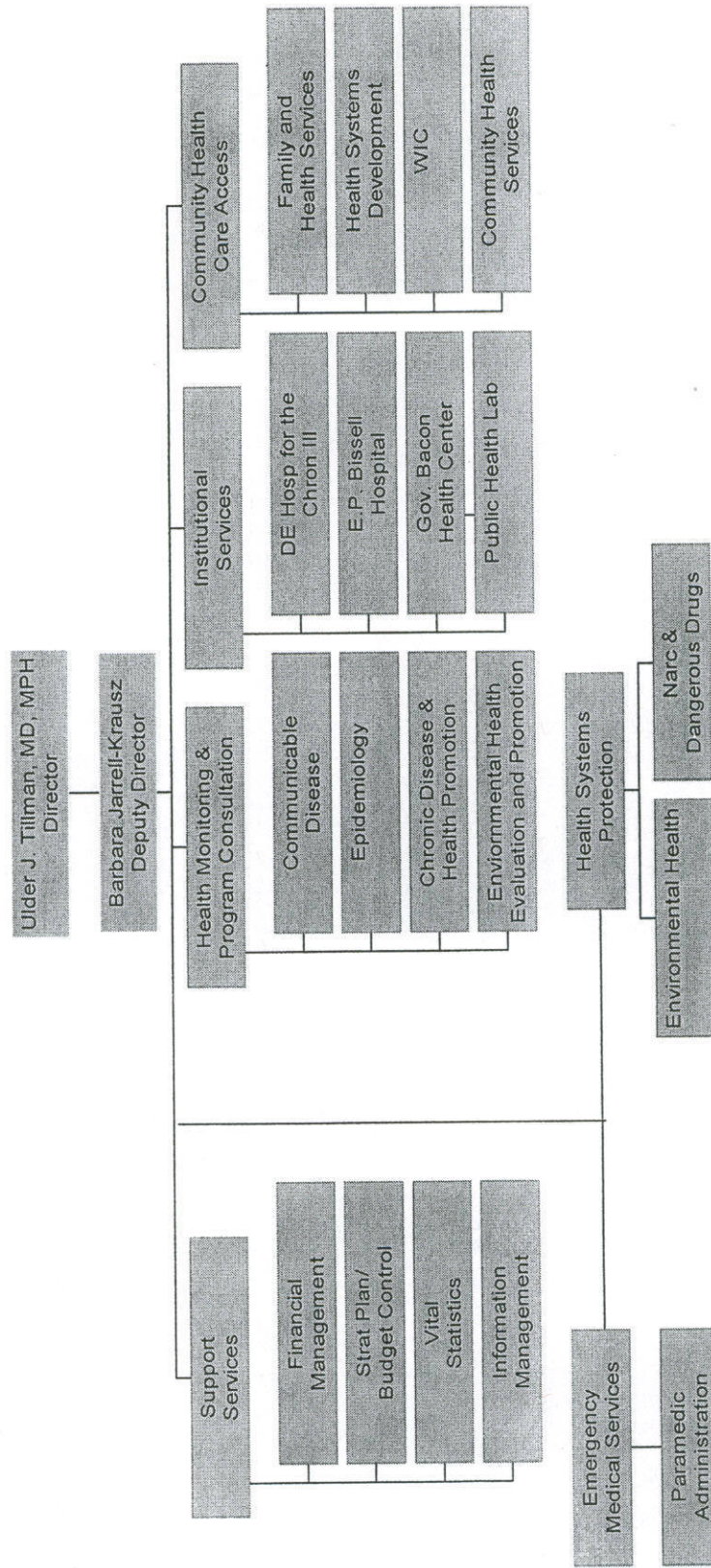
Carlyse Giddins, Director, DFS

Carl DeSantis, Secretary, DSCYF

Rev. 7/16/00



DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH



Glossary

Terms Frequently Used by DFS AND DPH

Caretaker: One who provides for the physical, emotional, and social needs of a dependent person, who often cannot provide for his or her own needs; most often applies to relatives, foster parents or licensed residential group homes, who are approved by the DFS or licensed child placing agencies. (Also known as caregiver)

Child Abuse and Neglect: The physical injury by other than accidental means: injury resulting in a mental or emotional condition which is a result of abuse or neglect; negligent treatment; sexual abuse; maltreatment; mistreatment; non-treatment; exploitation or abandonment of a child under the age of 18 (16 Del. C. Ch. 9). Delaware Division of Family Services investigates cases of abuse and neglect by family or household members, custodians and guardians.

Physical abuse is a non-accidental act by a parent or custodian which results in harm to the child. This may include unreasonable discipline.

Neglect addresses the lack of provision of basic needs inclusive of a safe place to live, sufficient food for growth and development, consistent attention and supervision and non-organic failure to thrive as a result of neglect. There are five basic types of neglect:

Medical Neglect: consistent failure to administer medications, to secure medical follow-up or to obtain needed medical therapy under persistent medical guidance, in both life threatening and non-life threatening situations. However, 16 Del. C. Ch. 9 §907 states that "no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall for that reason alone be considered a neglected child...". DFS will accept and investigate reports of life-threatening medical neglect made by medical personnel when medical treatment has been denied by the parents or custodians for religious reasons.

Educational Neglect: failure to enroll a child in school by the age of six years, or failure to enroll children by the age of three years who require therapies not provided elsewhere and for who such programs have been prescribed. Also failure to routinely send a child to school.

Abandonment: Occurs when a child is left without parental supervision or with a temporary caretaker for an extended period of time, and the parent cannot be located.

Emotional Neglect: failure on the part of the primary caregiver to provide the basic parental support and nurturance required by all children

Physical Neglect: failure to provide adequate food, clothing, shelter or routine physical care.

Intrafamilial Sexual abuse is a form of child abuse in which a child is compelled by manipulation or force to fulfill the sexual demands of an older person that is has the care and or custody of the child.

Child Development Watch (CDW): A program that offers identification, assessment, service coordination and intervention for children. Referrals for service are received through Child Development Watch Central Intake in Wilmington 800-671-0050 and Milford 800-752-9393.

Minimally Adequate Care: the point below which a family setting is inadequate for the care of a particular child, and therefore, the child is at risk of harm. Working definitions for minimally adequate care vary but should take into consideration parental action or inaction, cultural variations, poverty and the likelihood of harm to the child.

Non-Organic Failure to Thrive: the condition observed in children whose physical development is recorded at below the third percentile in height or weight for that specific age and for which there is no known medical reason.

Part C: Children birth to three years of age who have at least a 25% developmental delay in one of the five areas of development or who have an established condition that places them at high risk for a developmental delay are eligible for early intervention services under the federal mandate of IDEA, Part C.

Placement: A child is considered to be in placement if he or she is not living with a legal parent and the Division of Family Services has planning responsibility for the child through one of the following mechanisms:

Voluntary Consent for Placement: parents and legal custodians can sign a document allowing the Division to place the child for up to 180 days. During that time, the Division must either petition Family Court for custody or return the child. A Voluntary Consent is not a transfer of custody and the parents can revoke the consent with due notice.

Legal Custody awarded by Family Court. Parents retain the right and responsibility to make major decisions (e.g. medical, religious, educational) regarding their children while in substitute care.

Parental Rights in some cases, Family Court has terminated all parental rights and transferred those rights to DFS. In these cases, DFS has sole planning responsibility, including responsibility for signing consents to any and all medical treatment.

(Note: The home of a relative caretaker is considered to be a placement if one of the above legal conditions is met. If the child is placed under a Voluntary Consent to Place and the parent withdraws the consent to placement and places the child with the relative on his or her own authority, the child is not considered to be in placement).